State of Missouri Managed Care Quality Strategy

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MO HealthNet Division
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Section I: Introduction and Overview

Purpose

The goal of the Managed Care Program is to furnish high quality health care services resulting in measurable improvements in population health to members while providing the State with significant cost efficiencies. The State recognizes that the keys to a successful Managed Care Program include the provision of effective high-quality services, the satisfaction of members, and the involvement of stakeholders. Managed Care is an opportunity to deliver high quality, patient-centered, evidence-based care in a way that also stabilizes costs and gains budget predictability by making payments on a predetermined, per-member-per-month basis while establishing specific expectations for quality outcomes. It also provides a more accountable, coordinated system of care for beneficiaries, with an emphasis on preventive and primary care services, in addition to chronic disease services.

Missouri's Quality Improvement Strategy (QIS) is a comprehensive plan incorporating monitoring, evaluation, and ongoing quality improvement processes to coordinate, assess, and continually improve the delivery of quality care and services to participants in the Managed Care Program. The QIS provides a framework to communicate the State's vision, goals, objectives, and measures that address access to care, wellness and prevention, chronic disease care, cost effective utilization of services, and customer satisfaction. This comprehensive plan incorporates the processes of monitoring, assessment, and improvement.

Missouri Medicaid

The Medicaid Program, authorized by federal legislation in 1965, provides health care access to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children. Since that time, legislative options and mandates have expanded the categories of eligibility to include Medicaid coverage for children and pregnant women in poverty, children in state care, and non-disabled adults ages 19-64 with income up to 138% of the Federal Poverty Level (FPL). The Missouri Medicaid program is jointly financed by the federal government and State of Missouri and is administered by the State of Missouri. The agency charged with administration of the Medicaid program is the MO HealthNet Division (MHD), within the Department of Social Services. A portion of Missouri's Medicaid enrollees are covered under MO HealthNet Fee for Service and are not enrolled in the Managed Care Program.

MO HealthNet Fee for Service

The MO HealthNet Fee-for-Service Program serves our aged, blind, and disabled populations. Individuals are determined medically eligible based on permanent and total disability by receiving a medical determination of permanently and totally disabled by Missouri's Medical

Review Team (MRT). Individuals not required to certify permanent and total disability by MRT must meet the definition of disability as established by the Social Security Administration (SSA) and are receiving Supplemental Security Income (SSI) or Retirement, Survivor's, and Disability Insurance (RSDI) based on his/her disability. Verification of disability-based SSI or RSDI benefits is sufficient to establish permanent and total disability with proof of disability by SSA verified per the award letter or other notification received from SSA documenting the decision date.

Women's Health Services Program

MO HealthNet offers Women's Health Services to women ages 18 through 55 that have family income at or below 201% of the Federal Poverty Level (FPL) and are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), Medicare, or health insurance coverage that provides family planning services. There is no cost sharing for this coverage and services are obtained through the MO HealthNet fee-for-service program.

MO HealthNet Waiver Programs

In 1981, Congress enacted Section 2176 of Public Law 97-35 of the Social Security Act, entitled the Omnibus Budget Reconciliation Act. Through this enactment, certain statutory limitations have been waived to provide states that have received approval from the Department of Health and Human Services the opportunity for innovation in delivering home and community-based services to eligible persons who would otherwise require institutionalization in a nursing facility, hospital, or intermediate care facility for the developmentally disabled (ICF/DD). Approved Missouri waivers to provide services are listed at the following webpage: https://mydss.mo.gov/mhd/waiver-programs.

Disability

The definition of disability for MO HealthNet for the Disabled is aligned with the definition used to determine disability for Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) benefits. Specifically, disability is defined as:

"The inability to engage in any substantial gainful activity (SGA) due to a physical or mental impairment(s) that:

- Can be expected to result in death; or
- Has lasted or can be expected to last for a continuous period of at least 12 months."

Beneficiaries in Missouri qualify for these Medicaid benefits based on the following main eligibility criteria:

- Citizenship
- Residence in Missouri
- Having a valid Social Security number

- Being permanently and totally disabled
- Having countable assets below the established limits (note: some assets are excluded)
- Having a monthly income below the established limits

Streamlined Process for SSDI/SSI Recipients:

If an individual is receiving SSDI or SSI benefits, medical information is not required to establish disability for MO HealthNet. This facilitates a streamlined process for eligible individuals to access Medicaid benefits.

MO HealthNet Managed Care

A 1915(b) Waiver enables Missouri to use the managed care system to provide Medicaid services to Section 1931 children and related poverty level populations: Section 1931 adults and related poverty populations, including pregnant women, Children's Health Insurance Program (CHIP) children, and foster care children. Effective May 1, 2017, Managed Care was extended statewide in Missouri. Previously, Managed Care was only available in certain regions. A constitutional amendment was passed in August 2020 requiring the State to offer services to adults ages 19-64 with income up to 138% of the Federal Poverty Level. These adults began receiving services through the managed care system October 1, 2021 under Section 1932(a). For additional background on the operation of Managed Care in Missouri, please visit https://mydss.mo.gov/mhd/mc-history.

Managed Care Populations and Program Coverage

Managed Care Enrollment

Table 1 below shows each managed care health plan currently contracted with MO HealthNet along with enrollment as of January 1, 2024. Statewide coverage is provided by all health plans.

Table 1

Plan name	MCP Type	Managed Care Authority	Number of Enrollees*	Populations Served
Healthy Blue	MCO	1915(b), 1115	382,631	Medicaid children without disabilities, pregnant women, parents and expansion adults ages 19-64
Home State Health	MCO	1915(b), 1115	337,436	Medicaid children without disabilities, pregnant women, parents and expansion adults ages 19-64
Show-Me Healthy Kids	MCO – Specialty Plan	1915(b), 1115	48,962	Children in care and custody of the state and former foster care youth
UnitedHealthcare	MCO	1915(b), 1115	321,152	Medicaid children without disabilities, pregnant women, parents and expansion adults ages 19-64

Children's Health Insurance Program (CHIP)

Missouri's Children's Health Insurance Program (CHIP) was a Medicaid expansion implemented on September 1, 1998, through a waiver under Section 1115 of the Social Security Act, and subsequently through a Title XXI State Plan that covered children under the age of 19 in families with a gross income up to 300% of the Federal Poverty Level (FPL). Currently, coverage is provided statewide through the Managed Care delivery system.

Former Foster Care Youth (FFCY)

Effective July 1, 2021, MO HealthNet implemented the FFCY Section 1115 Demonstration to provide MO HealthNet coverage to Missouri residents who are former foster care youth under age 26, who were in foster care under the responsibility of another state for at least six months and as of the date they turned age 18, and who were enrolled in Medicaid while they were in foster care. Missouri will maintain MO HealthNet coverage for this population of former foster care youth, increase and strengthen overall coverage of former foster care youth in Missouri, and improve health outcomes for these youth.

Show-Me Healthy Babies

Starting on January 1, 2016, Missouri added coverage to the state's separate CHIP to include targeted pregnant women and unborn children from conception to birth. Eligible women have a household income up to 300% of the FPL when the mother is not eligible for Medicaid, CHIP or affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child. Targeted women and unborn children receive a benefit package of essential, medically necessary health services identical to the MO HealthNet for Pregnant Women benefit package. The

purpose is to provide pregnant women with access to prenatal care and an opportunity to connect individuals to longer-term coverage options.

MO HealthNet Managed Care Specialty Plan

MO HealthNet awarded a Specialty Plan contract to Home State Health Plan titled Show Me Healthy Kids. Effective July 1, 2022, all children in the care and custody of the state, children receiving adoption subsidy and Former Foster Care Youth were moved to the specialty plan. The specialty plan collaborated with the state agency to implement requirements to comply with the Family First Prevention Services Act of 2018 (PL115-123) and other programs impacting specialty plan members. Show Me Healthy Kids was established to provide a trauma-informed comprehensive and integrated Behavioral Health/Physical Health delivery system allowing these children and youth to grow into healthy adults and live full and satisfying lives. This plan will focus on ensuring these children and youth receive all comprehensive services, wrap around services, and care management. To further integrate care, behavioral health services, previously carved out of Managed Care, have been incorporated into the Show Me Healthy Kids benefit package. The specialty plan will be encouraged to provide additional health benefits that include social determinants of health needs, considering the special and unique needs of the plan population.

Section II: Quality Strategy Oversight and Monitoring

Under Managed Care, oversight responsibility is shared among the federal government, state government, the MCOs, and their providers. Federal regulations, 42 CFR 438.340(b) lay the groundwork for the development and maintenance of a quality strategy to assess and improve the quality of managed care services offered within a state. This quality strategy is intended to serve as a blueprint or road map for states and their contracted health plans in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. The State has direct oversight of its contracted MCOs and establishes payment rates for these entities as well as the parameters governing the amount, duration, and scope of benefits covered in these contracts. The MCOs establish standards dictated by the State for medical care, prior authorizations, and initial referral policies, determine payment methods, and rates for MCO providers.

Administrative activities, such as handling member grievances and provider appeals are carried out by the customer service and provider relations divisions within the MCOs with oversight by the State. The MCOs are accountable for improving the well-being of members. Customer service and care management functions provided by the MCOs contribute to improved member involvement and better health outcomes and provide an opportunity to improve the quality of care being furnished.

Quality Improvement Strategy

Development

The QIS is developed through collaborative partnerships with members, stakeholders, other state agencies, MCOs, tribal consultation, and community groups. This process is undertaken to ensure that:

- Quality health care services are provided to Managed Care members.
- Established benchmarks for outcomes are being met.
- MCOs are in compliance with Federal, State, and contract requirements; and,
- A collaborative process is maintained to collegially work with the MCOs to improve care.

Development of the QIS is a multi-step process. A review of the prior QIS is conducted, and findings are discussed among MHD administrative, program, and quality staff. Input is solicited from key stakeholders, and all information is considered when planning modifications to the QIS. After undergoing review by the Missouri Department of Social Services, a draft is distributed to key stakeholders and posted to MHD's website for a thirty (30) day public comment period. The State of Missouri will also consult with the federally recognized Indian tribe Kansas City Indian Center in accordance with the State's Tribal consultation policy and 42 CFR 438.340 (c)(ii). All feedback is reviewed by MHD and enhancements are incorporated into the Quality Strategy.

Effectiveness Review

The QIS will be reviewed at least annually. The Missouri EQRO will conduct a systematic review of progress made toward identified goals, objectives, and measures. The added benefit of having the EQRO's contribution to this review is they can provide technical assistance and recommendations based on their expertise in the quality arena. MHD will also assess progress made at the individual plan level and for Managed Care as a whole.

There are two categories of data used for these systematic reviews. First are the primary data sources that align with our established measures such as findings from the Healthcare Effectiveness Data and Information Set (HEDIS), Adult and Child Core Set, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Reviews will also utilize data from the annual "Secret Shopper Survey", Information Systems Capabilities Assessment (ISCA) and Network Adequacy Validation conducted by the EQRO. A number of measures that assess the cost effectiveness of healthcare services are provided to MHD via a partnership with another cabinet-level agency, the Department of Health and Senior Services (DHSS).

Revisions

Results of annual evaluations are reviewed and discussed with the MCOs to determine the root causes of why each strategy and intervention is or is not effective.

Results are used internally to guide program planning and development. This may lead to changes in proposed activities and interventions, methods of analysis, or revision of the measures themselves. MHD may also enlist the EQRO to provide technical assistance to one or more MCOs related to their performance.

Missouri's Quality Strategy is revised at least every three years, as required by CMS. Significant changes to the operation or scope of MHD's Managed Care Program (defined as anything that impacts quality operations) will also result in a revision of the QIS. An example would be changes to models of care.

Public Posting

The previous QIS, titled "2021 Quality Improvement Strategy" can be found at https://mydss.mo.gov/mhd/managed-care-archive. MHD updated our QIS in 2022 due to significant program changes, the 2022 update can be found at the following link: https://mydss.mo.gov/mhd/managed-care-health-plans. A formal evaluation of the 2021 and 2022 Quality Improvement Strategies is found under "Evaluation of the 2021 Quality Improvement Strategy". This document is a systematic evaluation of MCO progress toward meeting goals and objectives outlined in the 2021/2022 QIS.

2024 QIS Goals and Objectives

The MO HealthNet QIS is designed to communicate, assess, and evaluate the Managed Care Program's progress toward meeting its goals, objectives, and target measures. This is an intended roadmap for the Managed Care Program as a whole, with the understanding that individual MCO performance may vary from year to year for each measure. The QIS provides a framework to address access to care, wellness and prevention, outcomes, cost-effective utilization of services, and customer satisfaction. All of this has supported the Department's mission.

Mission

Empower Missourians to live safe, healthy, and productive lives.

MHD's vision statement specifies that *"Together we will build a **best in class** Medicaid program that addresses the needs of **Missouri's most vulnerable** in a way that is **financially sustainable**."* MHD's mission for the 2024 QIS is to set goals and objectives for

continuous quality improvement. The following table of measurable goals and objectives cover all populations served by our Managed Care Organizations.

The 2024 QIS is divided into four goals. Included within each one of these goals are objectives, measures and targets that will be used to measure progress on a yearly and longer-term basis, as described in the following tables.

Table 2
*MCO's are identified in the Performance Baseline and Target columns as follows:
1=Healthy Blue, 2=Home State Health, 3=United Healthcare, 4= Show Me Healthy Kids

Objective description	Measure	MCO performance baseline (CY2023)*	PY1 Target (CY2025)*
Goal 1: Ensure appropriate access to care for the state's Managed Care population by monitoring appointment standards and network adequacy. Note: Home State Health and Show Me Healthy Kids have a combined provider network.			
Target: Increase three (3) percentage points from previous year baseline or reach and maintain 90%+, as required in the Managed Care contract.			
Increase timely access to care for children and adults.	1.1 Percentage of PCP offices that met urgent appointment standards (within 24 hours)	1. 93.27 2. 85.17 3. 54.55	1. 93.27 2. 88.17 3. 57.55
	1.2 Percentage of PCP offices that met routine appointment standard w/o symptoms (within 30 days)	1. 98.99 2. 93.22 3. 48.48	1. 98.99 2. 93.22 3. 51.48
	1.3 Percentage of Psychiatrist offices that met routine appointment standard for behavioral health and substance use services without symptoms (within 2 weeks)	1. 25.13 2. 18.47 3. 15.79	1. 28.13 2. 21.47 3. 18.79
Target: Reach and maintain 100% access within mandated time or travel distance standards.			
Ensure an adequate healthcare network.	1.4 Percentage of members living within mandated time and travel distance standards of in-network PCPs.	1. 100 2. 100 3. 100	1. 100 2. 100 3. 100
	1.5 Percentage of members living within mandated time and travel distance standards of in-network specialists.	1. 100 2. 100 3. 100	1. 100 2. 100 3. 100
	1.6 Percentage of members living within mandated time and travel distance standards of an in-network basic hospital.	1. 98 2. 98 3. 99	1. 100 2. 100 3. 100

Table 3

Objective description	Measure	MCO performance baseline rate (MY2023)	MCO National Percentile (QC2024)	National Benchmark Rate 50th (QC2024)	MCO PY1 Target (MY2025)
Goal 2: Promote the health and wellness of Managed Care members through use of preventative services.					
Target: Two percentage point annual increase or reach and maintain above the 50th national percentile, as published annually on the NCQA Quality Compass. Projected target is an estimate (currently 2 percentage points), as actual national percentile rates are not available until Fall of each year.					
Promote child health through increase of well care visits, evaluations and immunization.	2.1 Well-child visits, ages 0-15 months (HEDIS and Child Core Set W30)	1. 57.31 2. 57.78 3. 54.96 4. 64.79	1. 33.33rd 2. 33.33rd 3. 25th 4. 66.67th	60.38	1. 59.31 2. 59.78 3. 56.96 4. 66.79
	2.2 Well-child visits, ages 15-30 months (HEDIS and Child Core Set W30)	1. 60.27 2. 59.99 3. 58.33 4. 73.97	1. 10th 2. 10th 3. 5th 4. 75th	69.43	1. 62.27 2. 61.99 3. 60.33 4. 75.97
	2.3 Child & Adolescent Well-Care visits, ages 3-21 (HEDIS and Child Core Set WCV Total)	1. 43.22 2. 43.72 3. 41.85 4. 49.57	1. 10th 2. 10th 3. 10th 4. 33.33rd	51.81	1. 45.22 2. 45.72 3. 43.85 4. 51.57
	2.4 Childhood Immunization Status (HEDIS and Child Core Set CIS - Combo 10)	1. 21.17 2. 16.79 3. 21.65 4. 14.36	1. 10th 2. 5th 3. 10th 4. <5th	27.49	1. 23.17 2. 18.79 3. 23.65 4. 16.36
	2.5 Immunizations for Adolescents, age 13 years old (HEDIS and Child Core Set IMA -Combo 2)	1. 20.68 2. 21.02 3. 17.52 4. 22.38	1. <5th 2. <5th 3. <5th 4. 5th	34.30	1. 22.68 2. 23.02 3. 19.52 4. 24.38
	2.6 Oral Evaluation, Dental Services, age under 21 years old (HEDIS OED – Total)	1. 38.99 2. 37.42 3. 37.70 4. 47.44	First year measure, percentile not published.	First year measure, percentile not published.	1.40.99 2. 39.42 3. 39.70 4. 49.44
Address Chronic Disease Management	2.7 Asthma Medication Ratio, age 5-64 (HEDIS AMR-Total)	1. 65.20 2. 60.69 3. 59.37 4. 68.20	1. 33.33rd 2. 25th 3. 10th 4. 50th	66.24	1. 67.20 2. 62.69 3. 61.37 4. 70.20
	2.8 Diabetes Care (HEDIS GSD - <8.0%)	1. 56.20 2. 51.58 3. 55.23	1. 33.33rd 2. 25th 3. 33.33rd	57.42	1. 58.20 2. 53.58 3. 57.23

		4. 41.72	4. 5th		4. 43.72
Promote Women's Health	2.9 Timeliness of Prenatal Care (HEDIS PPC)	1. 88.08 2. 80.29 3. 84.91 4. 80.82	1. 66.67th 2. 25th 3. 50th 4. 25th	84.55	1. 90.08 2. 82.29 3. 86.91 4. 82.82
	2.10 Postpartum care Visits (HEDIS PPC)	1. 81.27 2. 72.02 3. 81.27 4. 75.47	1. 50th 2.10th 3. 50th 4. 10th	80.23	1. 83.27 2. 74.02 3. 83.27 4. 77.47
	2.11 Chlamydia Screening in Woman, ages 16-24 (HEDIS and Adult Core Set CHL Total)	1. 39.61 2. 53.51 3. 51.36 4. 53.25	1. 5th 2. 33.33rd 3. 25th 4. 33.33rd	55.95	1. 41.61 2. 55.51 3. 53.36 4. 55.25
Goal: 3 Ensure cost-effective utilization of services.					
Target: Two percentage point annual increase or reach and maintain above the 50th national percentile, as published annually on the NCQA Quality Compass. Projected targets are estimates (currently 2 percentage points), as actual national percentile rates are not available until Fall of each year.					
Decrease readmission rates	3.1 Follow-Up after hospitalization for Mental Illness, ages 6+ (FUH 30 day Total HEDIS)	1. 52.30 2. 50.58 3. 45.45 4. 74.32	1. 10th 2. 10th 3. 10th 4. 75th	59.85	1. 54.30 2. 52.58 3. 47.45 4. 76.32
	3.2 Follow – Up after Emergency Department Visit for Mental Illness (FUM 30 day Total HEDIS)	1. 44.04 2. 41.17 3. 39.51 4. 60.16	1. 10th 2. 10th 3. 10th 4. 66.67th	53.82	1. 46.04 2. 43.17. 3. 41.51 4. 62.16
Goal 4: Promote member satisfaction with experience of care. Measures 4.1 thru 4.3 relate to the Medicaid Child- general population CAHPS survey. Measures 4.4 thru 4.6 relate to the Medicaid Adult CAHPS survey. Note: CAHPS surveys are not submitted separately for Home State Health and Show Me Healthy Kids, results are combined below.					
Target: Two percentage point annual increase or reach and maintain 75th national percentile. Projected targets are estimates (currently two percentage points), as actual national percentile rates are not available until Fall of each year.					
CAHPS surveys do not have a one-year lag.		MCO MY2023 Baseline Rate	MCO National Percentile (QC2024)	National Benchmark Rate 75th (QC2024)	MCO PY1 Target (MY2025)
Should Promote access to	4.1 Rate of usually or always getting care as soon as needed within the last six months.	1. 84.17 2. 81.90 3. 86.00	1. 50th 2. 33.33rd 3. 66.67th	86.60	1. 86.17 2. 83.90 3. 88.00

care – Child CAHPS	4.2 Rate of usually or always getting care quickly within the last six months.	1. 90.27 2. 91.80 3. 91.30	1. 75th 2. 75th 3. 75th	90.22	1. 92.27 2. 93.80 3. 93.30
Promote rating of healthcare – Child CAHPS	4.3 Increase member healthcare satisfaction ratings to score an 8,9, or 10 within the last six months.	1. 84.10 2. 91.30 3. 86.50	1. 10th 2. 90th 3. 50th	88.89	1. 86.10 2. 93.30 3. 88.50
MHD began collecting Adult CAHPS Surveys in 2024.		MCO MY2023 Baseline Rate	MCO National Percentile (QC2024)	National Benchmark Rate 75th (QC2024)	MCO PY1 Target (MY2025)
Target: Two percentage point annual increase or reach and maintain the 75th national percentile. Projected targets are estimates (currently 2 percentage points), as actual national percentile rates are not available until Fall of each year.					
Promote access to care – Adult CAHPS	4.4 Rate of always or usually getting care as soon as needed within the last six months.	1. 75.5 2. 87.7 3. 81.8	1. 5th 2. 95th 3. 33.33rd	84.90	1. 77.5 2. 89.7 3. 83.8
	4.5 Rate of always or usually getting care quickly within the last six months.	1. 78.6 2. 85.6 3. 87.6	1. 25th 2. 75th 3. 90th	83.76	1. 80.6 2. 87.6 3. 89.6
Promote rating of healthcare – Adult CAHPS	4.6 Increase member healthcare satisfaction ratings to score an 8,9, or 10 within the last six months.	1. 71.0 2. 74.8 3. 72.1	1. 5th 2. 25th 3. 10th	80.5	1. 73.0 2. 76.8 3. 74.1

Quality Metrics and Performance Targets

Additional metrics and targets, described in table 4, are being added to the Quality Strategy following MHD's review of HEDIS and Adult/Child Core Set measure results, submitted through quality reporting. In comparison to National Benchmarks, managed care plans scored below the 50th percentile on most of these measures presenting MHD with an opportunity to request additional focus for these specific healthcare services.

Table 4

*MCO's are identified in the Performance Baseline and Target columns as follows:
1=Healthy Blue, 2=Home State Health, 3=United Healthcare, 4= Show Me Healthy Kids

Metric Name	Metric Specification	Baseline Performance MY2023	MCO National Percentile (QC2024)	National Benchmark Rate 50th (QC2024)	Performance target PY1 (MY2025)
Target: Increase two percentage points annually or reach and maintain the 50th national percentile. Projected targets are estimates (currently 2 percentage points), as actual national percentile rates are not available until Fall of each year.					
1.Adults' access to Preventive/Ambulatory Health Services (AAP)					
Adult's access to preventive/ambulatory health services (AAP Total)	HEDIS	1. 71.94 2. 72.81 3. 73.92 4. 56.47	1. 33.33rd 2. 33.33rd 3. 33.33rd 4. <5th	74.88	1. 73.94 2. 74.81 3. 75.92 4. 58.47
2. Weight Assessment and Counseling for Nutrition and Physical Activity (WCC)					
BMI Percentile (Total)	HEDIS and Child Core Set	1. 74.21 2. 56.20 3. 70.80 4. 57.42	1. 10th 2. <5th 3. 10th 4. 5th	82.73	1. 76.21 2. 58.20 3. 72.80 4. 59.42
Counseling for Nutrition ages 3-17 (Total)		1. 61.80 2. 49.15 3. 38.69 4. 49.88	1. 10th 2. 5th 3. <5th 4. 5th	71.78	1. 63.80 2. 51.15 3. 40.69 4. 51.88
Counseling for Physical Activity ages 3-17 (Total)		1. 56.45 2. 43.55 3. 31.63 4. 45.74	1. 10th 2. 5th 3. <5th 4.5th	68.33	1. 58.45 2. 45.55 3. 33.63 4. 47.74
3. Lead Screening in Children (LSC)					
Lead Screening in Children (LSC)	HEDIS and Child Core Set	1. 56.45 2. 57.34 3. 54.99 4. 64.93	1. 25th 2. 25th 3. 25th 4. 50th	63.84	1. 58.45 2. 59.34 3. 56.99 4. 66.93
4. Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure (CBP)	HEDIS and Adult Core Set	1. 64.23 2. 54.50 3. 57.18 4. 68.25	1. 33.33rd 2. 5th 3. 10th 4. 66.667th	64.48	1. 66.23 2. 56.50 3. 59.18 4. 70.25
5. Cervical Cancer Screening (CCS)					

Cervical Cancer Screening, ages 21-64 (CCS)	HEDIS and Adult Core Set	1. 49.64 2. 46.23 3. 47.69 4. 41.18	1. 25th 2. 10th 3. 10th 4. 10th	57.18	1. 51.64 2. 48.23 3. 49.69 4. 43.18
6. Prenatal Immunization Status (PRS-E)					
Influenza	HEDIS	1. 21.79 2. 21.97 3. 18.63 4. 22.02	1. 33.33rd 2. 33.33rd 3. 25th 4. 33.33rd	25.1	1. 23.79 2. 23.97 3. 20.63 4. 24.02
Tdap		1. 55.15 2. 56.23 3. 58.76 4. 57.19	1. 33.33rd 2. 33.33rd 3. 50th 4. 50th	56.53	1. 57.15 2. 58.23 3. 60.76 4. 59.19
Combination		1. 17.75 2. 18.56 3. 15.70 4. 18.04	1. 33.33rd 2. 33.33rd 3. 25th 4. 33.33rd	20.85	1. 19.75 2. 20.56 3. 17.70 4. 20.04

Section III: Quality Management Structure and Support

Staffing

Within MHD, the EBDSU and MCPCCU each play an important role in quality improvement on an ongoing and annual basis. To underscore MHD's commitment to quality improvement, it has created a Quality Oversight Unit consisting of a Quality Manager and five Research Data Analysts to focus specifically on quality improvement processes. A Registered Nurse was also added to the Quality Oversight Unit to provide clinical expertise in policy development, quality, and compliance arenas.

Medicaid Transformation

One of the guiding principles in the Managed Care Program is the Medicaid Reform and Transformation Program. This principle is supported through contract provisions that require the MCOs participate in five different types of initiatives. First are member incentive programs that encourage personal responsibility related to health behaviors and outcomes. The second are provider incentive programs. Provider incentive programs involve financial rewards for achieving established goals such as reaching a target number of qualifying patient visits or other quality benchmarks. The third is accountability and transparency, which focuses on health plan fraud and abuse activities and operational data reporting requirements. Value-based purchasing is another incentive in which the state agency may require the health plans to participate in a state- selected Value-Based

Purchasing Model and/or Purchasing Strategy during any period of the contract. These strategies seek to improve overall health and well-being of members and reduce cost.

Additionally, in 2018, MO HealthNet created the Office of Transformation which is positioned outside of the normal operating units and focuses solely on efforts that can enhance the structure and performance of Missouri's Medicaid program. The Office of Transformation was an integral part in handling the public health emergency effort related to the COVID-19 pandemic. This office developed data analytics which were utilized to make policy decisions to ensure that disruption to Missouri's Medicaid program remained at a minimum level.

Although the Office of Transformation is outside of our normal operating units, much of the work relies heavily on those staff members to implement system and policy changes, all while maintaining their daily duties, to move the program forward. To date, MHD has completed or has in flight, over 75 transformational initiatives.

Transformational initiatives occur throughout MHD, even within the operating units. Initiatives to date include, but are not limited to, the following:

- Day one enrollment for managed care members.
- Implementation of a new hospital outpatient and inpatient payment methodology with a current effort to transition to diagnosis related groupers (DRGs).
- Development of a revised care management evaluation.
- A single-MCO model with specialized capabilities for our children in state care and custody population began July 1, 2022, which includes behavioral health services being covered through managed care for this population.
- Development of a request for proposal for a managed care contract compliance tool to electronically evaluate quality data received from contracted MCOs.
- Public-facing quality dashboards to ensure transparency with stakeholders.
- Increases in dual eligibility enrollment in Medicaid to reduce costs to the Medicaid program.
- The development of a Health Data Utility to coordinate all the state's health data assets.
- Launch of the Transformation of Rural Community Health (ToRCH) model.
- Implementation of meaningful policies to improve maternal and infant health outcomes.
- Implementation of pharmacy program integrity measures to minimize fraud and abuse in prescribing practices.

Quality Data Review

The Quality Data Review (QDR) committee provides a consistently scheduled opportunity for clinicians, managers, and administrators to review the variety of quality data that are received, primarily in the monthly and quarterly data feeds, from the MCOs. The committee was formed to ensure reports based on these data were reviewed and acted upon in a timely manner.

MHD analyzes the data for trends, areas of concern, and development of interventions to address problematic or recalcitrant findings which are discussed during quarterly meetings. As MHD evaluates performance, it identifies areas of opportunity or weakness and works with the MCOs to improve performance. In addition, MHD uses corrective action plans to address deficiencies identified through evaluation of the MCOs. Additional follow-up with internal MHD staff and MCOs occurs when noncompliance or inconsistencies are discovered.

The MCOs provide MHD with monthly operational data on:

- Institution of Mental Disease (IMD) Services
- Member Grievance and Appeals
- Health Plan Hospital Services Reporting

The MCOs provide MHD with quarterly operational data on:

- Call Center Services
- Care Management Services
- Critical Incident Activities
- Disease Management Activities
- Fraud, Waste, and Abuse
- Improvement Plan Activities
- Overpayments Due to Fraud Activities
- Prior Authorizations and Denials
- Private Duty Nursing Services
- Provider Complaint and Appeals
- Third Party Savings
- Timeliness of Claims Adjudication

Quality Assessment and Improvement Advisory Group

The Quality Assessment & Improvement (QA&I) Advisory Group was created with the inception of Managed Care. The purpose of the QA&I Advisory Group is to impact service utilization and quality through collaborative monitoring and continuous quality improvement activities. The Managed Care Quality Oversight Unit conducts planning meetings to prepare for each public forum. The QA&I is facilitated by a chairperson designated by MHD, currently a Senior Director of Quality Improvement from one of the health plans. The QA&I Advisory Group assists in maintaining an open forum for collaboration and communication among MCOs, other stakeholders, and state agencies. Invited participants include MHD staff members and management, MCO staff, Missouri Medicaid Audit and Compliance Unit (MMAC), Missouri Family Support Division, Missouri Children's Division, Department of Mental Health, Department of Health and Senior Services, legal advocates, the state's financial actuary, Missouri Hospital Association, Missouri Primary Care Association, Children's Mercy Integrated Care Solutions, and is open to the public. The QA&I Advisory Group conducts public meetings semiannually in

the spring and fall.

The QA&I group continues to make recommendations to ensure the focus remains on developing meaningful quality improvement ideas. Meetings take place twice per year to review quality data analysis and evaluation activities to determine if improvements or new opportunities need to be explored. To generate greater discussion surrounding quality improvement processes by the plans, and expectations by MHD, agendas are modified to keep the group innovative. The QA&I has been helpful in developing strategies that MHD can implement to drive quality improvement. The QA&I meeting minutes and presentations are shared with attendees before becoming available to the public on MHD's website at the following link: https://mydss.mo.gov/mhd/qai/meetings.

Quality Measurement and Improvement

DHSS compiles the *Maternal and Child Health Indicators and Trends Report* from publicly reported vital health statistics and hospital discharge data sets each year. Aggregate data from the Managed Care Program baseline (1995 to the present) are available for nine maternal/infant and four child health indicators. This is presented at a QA&I meeting annually.

The Maternal and Child Health (MCH) Indicators are also used to examine the impact of the Managed Care Program on maternal/infant and child health and to compare this progress with Non-Medicaid and MO HealthNet Fee-for-Service participant groups.

MHD clinical staff conduct annual reviews of behavioral health and physical health care management, disease management, and utilization management services operated by the health plans. The resulting data from these efforts drive program and policy decisions and assist in identifying opportunities for quality improvement.

Performance Improvement Projects

A Performance Improvement Project (PIP) is a project conducted by the MCO designed to achieve significant improvement, sustained over time, in health outcomes and enrollee experience. A PIP may be designed to change behavior at a member, provider, and/or MCO/system level. MCOs are required to conduct PIPs that focus on both clinical and nonclinical areas each year as part of the plan's quality assessment and performance improvement (QAPI) program, per 42 CFR 438.330 and 457.1240(b).

The MCOs are all required to participate in two PIPs that address specific agency goals and priority areas. The two PIPs, one clinical and one non-clinical, will be reviewed by the EQRO on an annual basis. PIPs are targeted at improving quality measures such as HEDIS, Adult and Child Core Set and/or CAHPS data, mandated nationally by CMS and/or NCQA. Table 5 below outlines the two PIPs and their key performance measures.

Table 5

PIP Topic Area	PIP Aim	PIP Intervention
<u>Non-Clinical</u> **One non-clinical PIP of the health plans choosing, subject to review and approval by MHD. The chosen topic area shall be identified with a standardized performance measure to evaluate progress. For purposes of this requirement, a standardized performance measure means a quantifiable, evidence-based metric developed and maintained by a recognized organization, such as the National Committee for Quality Assurance (NCQA), that assesses and improves healthcare quality, patient outcome, and accountability. To ensure meaningful improvement, the health plan shall select a topic area where there is opportunity for growth.**	The MCO shall set a goal each year to improve the specified performance measure by at least three percentage points or reach and maintain the 50th national percentile.	The state will require its MCOs to conduct a non-clinical PIP, of their choosing, that is expected to have a favorable effect on health outcomes and member satisfaction. PIPs will include an aim statement, analysis, PDSA cycles, performance measurement and evaluation, a control condition, problem mapping and root cause analysis, and post-action planning.
<u>Clinical</u> **One clinical PIP, designed to address inpatient re-admission for mental health.**	The MCO shall set a goal each year to improve the HEDIS measure, Follow-up After Hospitalization for Mental Illness 30 Calendar Days (FUH-30), by at least three percentage points or reach and maintain the 50th national percentile.	The state will require its MCOs to conduct a clinical PIP, with a focus on inpatient re-admission for mental health, that is expected to have a favorable effect on health outcomes and member satisfaction. PIPs will include an aim statement, analysis, PDSA cycles, performance measurement and evaluation, a control condition, problem mapping and root cause analysis, and post-action planning. The MCOs shall provide an in-person contract plan if an improvement strategy aims to contract members to evaluate and address their personal barriers with a follow-up appointment after inpatient mental health hospitalization. This detailed plan for establishing in-person contact will define specific alternative contact plans for members who are unable to be reached through traditional outreach methods.

The PIP for improving the rate of follow up visits after hospitalization for a mental illness was introduced in July 2020. The MCOs and MHD collaborated through a workgroup, focused on improving performance before transitioning this measure into an official PIP beginning in calendar year 2023.

MO HealthNet interventions for these PIPs include program support starting with review/approval of PIP plans and analysis of performance at the end of each calendar year. A collaboration of MHD staff, MCOs (including subcontractors), clinical professionals, and multiple medical associations across the state focus on improving quality measures through improving access, quality, and timeliness of care.

Transition of Care

The MO HealthNet, Managed Care, Transition of Care policy is publicly available in the Managed Care Contract located at: https://mydss.mo.gov/media/pdf/mc-contract-amendment-7-effective-01012024 . The policy requires newly enrolled members and members transitioning from one health plan to another, moving to or from Fee-For-Service, or moving to or from the Specialty Plan to receive, at a minimum, the following services:

- Transfer of relevant member information including medical records and other pertinent materials to ensure a smooth transition.
- Care coordination for prescheduled health services, access to preventive and specialized care, care management, member services, and education with minimal disruption to members' established relationships with providers and existing care treatment plans.
- Smooth transfer of care from out of network providers to appropriate in- network providers.
- Continuity of care for medically necessary covered services.
- Ensure that any member entering the health plan is held harmless by the provider for the costs of medically necessary covered services except for applicable Managed Care Program cost sharing.
- Ensure non-pregnant members receiving a physician authorized course of treatment to continue to receive such treatment, without any form of prior authorization and without regard to whether such services are being provided by in-network or out-of-network providers, for the lesser of sixty (60) calendar days or until the member has been seen by the assigned primary care provider who has authorized a course of treatment.
- Ensure members in their third trimester of pregnancy continue to receive services from their prenatal care provider (in-network or out-of-network) without any form or prior authorization, through the postpartum period (defined as 12 months from last date of pregnancy).
- Ensure pregnant members continue to receive services from their behavioral health treatment provider, without any form of prior authorization, until the birth

of the child, the cessation of pregnancy, or loss of eligibility.
- Ensure that inpatient and residential treatment days are not prior authorized during transition of care.

Section IV: MO HealthNet Managed Care Programs and Standards

Performance Withhold Program

A performance withhold program began in 2015 with a goal to improve performance on selected quality metrics. MHD has consistently collaborated with the MCOs to promote continuous improvement and implement measures that will drive improvements in care and quality within Missouri's managed care program. MHD retains 2.5% of the annual capitated payments from all three general plans, which they may earn back by meeting targets set for the program.

Beginning in State fiscal year 2020, MHD transitioned our Performance Withhold Program to focus on HEDIS measures calculated and reported by the MCOs' certified HEDIS vendors. MHD sets program targets for year over year rate increases and/or reaching national percentiles for selected measures. Payout is determined by comparing prior year baseline rates to current year rates and/or current year rates to national percentiles published on NCQA's Quality Compass. Additional HEDIS rate information by MCO is available at the following link: https://mydss.mo.gov/mhd/quality-dashboard.

The State Fiscal year 2025 Performance Withhold Program will be evaluated on 12 HEDIS measures focusing on the following categories:

- Access to Care for Children
- Screening and Immunizations for Children
- Chronic Disease Management - Adults
- Women's Health
- Prevention and Screening

For the most part MCOs have historically met targets to receive release of the full withhold. However, results of the SFY2023 review determined two of the three MCOs were unable to recoup the full 2.5% payout. MHD began to adjust the SFY2024 and SFY2025 programs to focus on certain HEDIS measures that MHD, Mercer, and the MCOs determined were aligned with program goals. The intent of lowering the number of measures and measure categories is to focus MCO resources and promote improvement, as HEDIS rates in the program are currently on the lower end of NCQA national percentiles.

Grievances and Appeals

Member Grievance and Appeal

All health plans are required to have a written grievance and appeal system for members that includes the process for both grievances and appeals. An appeal is defined as a review by a health plan of an adverse benefit determination.

Members have 60 calendar days from the date on the adverse benefit determination notice to file a request for an appeal to the health plan. Health plans must acknowledge receipt of each appeal in writing within ten calendar days after receiving the appeal and must resolve each appeal and provide written notice of resolution no more than 30 calendar days past the filing date. Health plans must continue the member's benefits if the member files a timely appeal and the appeal involves a termination, suspension, or reduction of a previously authorized course of treatment, the services were ordered by an authorized provider, the original period covered by the authorization has not expired, and the member requests continuation of the benefits.

A grievance is defined as an expression of dissatisfaction about any matter other than an adverse benefit determination including, the quality of care or services provided, the aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. Health plans must acknowledge receipt of each grievance in writing within ten calendar days after receiving a grievance and must resolve each grievance and provide written notice of resolution no more than 30 calendar days past the filing date.

Health plans must ensure that the individuals who make decisions on appeals and/or grievances are individuals who were neither involved in any previous level of review or decision-making and who have the appropriate clinical expertise in treating the members condition or disease (if the appeal is a denial for lack of medical necessity, if a grievance is regarding denial of expedited resolution of appeal, or if a grievance or appeal involves clinical issues). Health plans are required to maintain records of grievances and appeals, whether received verbally or in writing and include the description of the reason for the grievance or appeal, the date it was received, the date of each review, the resolution, the date of the resolution, and the name of the member for whom the grievance or appeal was filed.

Provider Complaint and Appeal

Health plans must also establish a provider complaint and appeal system that includes access to provider specific disputes between the health plan and providers. A provider appeal allows providers the right to appeal actions of the health plan for the following reasons:

1. The denial, in whole or in part, of payment for a service;
2. A claim for reimbursement not acted upon with reasonable promptness; or
3. Is aggrieved by any rules or regulation, policy or procedures, contractual agreement, or

decision by the health plan.

A provider compliant is defined as a verbal or written expression by a provider which indicates dissatisfaction or dispute with health plan policy, procedure, or any aspect of health plan functions. Health plans must have policies and procedures written to detail how providers file a complaint or appeal, whether it must be in writing, information on the amount of time a provider must file and the resolution timeframe, and a process for thoroughly investigating each compliant and appeal. All policies and procedures must be submitted to MHD for prior approval.

Healthy Birthweight Incentive (HBWI) Program

MHD is developing a healthy birthweight incentive program that is expected to begin in January 2025. This incentive will provide the MCOs a bonus payment that is based on the actuarial cost difference between a low-birthweight baby and a healthy-birthweight baby. This incentive will be calculated based on annual low-birthweight rates per MCO. MHD anticipates this program will help in reducing disparities.

Prenatal Care Adequacy Index (PCAI) Program

MHD is also developing a prenatal care adequacy index program that is expected to begin in January 2025. This program will pay the MCOs a bonus payment for each mom who is determined to have "adequate" or better prenatal care according to a modified Kotelchuck Index calculation based on encounter data. This bonus will be adjusted for moms not being enrolled in the health plan for the entire pregnancy. MHD anticipates this program will help in reducing disparities.

Community Health Initiatives

Certified Community Behavioral Health (CCBHOs)

A major area of strength has been the ongoing partnerships with DMH to improve health outcomes for those accessing behavioral health services through community mental health centers and/or certified community behavioral health organizations. Another initiative underway involves collaboration among inpatient behavioral health facilities, MCOs, and community providers in order to improve communication, coordination, and collaboration among all partners following inpatients admissions. Collaborations with DHSS have been helpful to improve health outcomes for the Maternal and Child population. Additionally, we solicit input through public meetings and continually monitor this feedback for opportunities for improvement.

Transformation of Rural Community Health

CMS approved a 1915(b) waiver March 25, 2024 for Missouri to begin the Transformation of Rural Community Health (ToRCH) pilot project. ToRCH is a model of care that directs resources to rural communities and addresses the causes of poor health through integrating social care supports into clinical care. The ToRCH project establishes community-based hubs that serve as

regional leads to direct strategy and coordinate the efforts of healthcare providers, community-based organizations (CBOs), and social service agencies within a designated rural community.

Six rural hospitals have been selected as ToRCH hubs for the first cohort:

- Dent County: Salem Memorial District Hospital – Salem, MO
- Henry County: Golden Valley Memorial Healthcare – Clinton, MO
- Pettis County: Bothwell Regional Health Center – Sedalia, MO
- Phelps County: Phelps Health – Rolla, MO
- Polk County: Citizens Memorial Hospital – Bolivar, MO
- Ray County: Ray County Hospital – Richmond, MO

Additional rural hospital and counties may be selected as the project continues to grow but must meet the Federal Office of Rural Health Policy definition of rural to be eligible. Community-based organizations and health and human services organizations in the target counties are welcome to participate in ToRCH by contracting the hub organization.

The goals for this project are to better leverage existing social care funding, to create a new path to sustainability for rural hospitals and improve clinical outcomes in our Medicaid population. The ToRCH program will be powered by Unite Us, a national leader in software enabling cross-sector collaboration to improve people's health and well-being. Through Unite Us, partners will be able to manage eligibility and authorization, send referrals to contracted providers, securely track outcomes and document services, efficiently manage reimbursement of social care services, and connect activities back to improved health outcomes.

Notification of Pregnancy Project

MO HealthNet, our health plans, and a select group of providers began a pilot project in calendar year 2024 to develop a uniform Notice of Pregnancy. The unified form allows providers to screen patients for potential physical pregnancy risks, behavioral health concerns and social determinants of health. The form is then uploaded to MHD, who sends the form to the correct health plan. The health plan then stratifies the risk of the member to provide expedited outreach and resources to the member. Communication between the providers and health plans allows for increased contact with members who have previously been unable to be reached. The pilot program plans to go live statewide by the beginning of calendar year 2025.

Care Management Program

Care Management is a process of identification, assessment, enrollment of members into Care Management services, monitoring of illness or condition and discharge from services, when appropriate. The care management requirements are comprehensive and have evolved over time as newer data from MHD program evaluations have emerged to inform these requirements. Part of that evolution is the incorporation of the principles

used in MHD Section 2703 Health Home Program (see below). In addition to incorporating those principles within the Managed Care contract, MCOs are historically required to assess members for care management within a specified number of days after enrollment or diagnosis with specific conditions and/or risk factors. MCOs are required to submit quarterly reports showing the outreach attempts, members enrolled and discharged from Care Management. Care Management reports include the Member Journey Mapping and the Improvement Plan template. Care management programs apply systems, science, incentives, and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical/social/mental health conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while providing cost effective, non-duplicative services.

Special populations require more intensive care management. MCOs are required to offer care management within five (5) business days of admission to a psychiatric hospital or residential substance-use treatment program. MCOs are required to offer care management within fifteen (15) business days of notification of pregnancy. Children with elevated blood lead levels must be assessed for care management within these timeframes, depending on the degree of elevation:

- ✓ 10 to 19 μg/dL within one to three (1-3) business days;
- ✓ 20 to 44 μg/dL within one to two (1-2) business days;
- ✓ 45 to 69 μg/dL within twenty four (24) hours; and
- ✓ 70 μg/dL or greater – immediately.

MHD recognizes that these lead levels are behind those endorsed by the CDC. DHSS is currently working on a state regulation that will align with national guidelines. The Managed Care contract will be updated to require care management for elevated blood lead levels, within specified timeframes, as defined by regulatory changes. MHD regularly collaborates with the health plans and DHSS on the lead program to monitor compliance.

Care Management Review

MHD's strategy for ongoing monitoring and continuous quality improvement of MCO Care Management (CM), includes tools to identify progress or lack of progress on CM structure, process, and outcome measures. The reporting system allows MHD to identify early signs and problem areas through regular reporting on CM Program measures. The retrospective analysis provides a targeted review to drill down on identified CM priority and problem areas.

Reporting system:
The reporting system provides data for monitoring and oversight of the program and consists of reviewing MCO self-reported data. The goal of all monitoring and oversight is to

be able to quickly identify variances from expectations and take rapid action to investigate before issues become more significant. Examples of specific reports and monitoring forums include:

- Quarterly CM Report
- Quarterly MCO CM Meetings
- Annual CM Member survey
- Annual Review of QAPI and Care Management Program Description and Evaluation
- CM new policy review
- Review of documentation and progress for the PIP "Improving the rate of follow up visits after a hospitalization for a mental illness."

Responsibility:
The Quality Data Review Committee is responsible for monthly, quarterly, and annual review and analysis of data, feedback and dialogue with MCOs. Results are discussed with individual MCOs and the QA&I.

Retrospective Analysis:
The retrospective analysis is typically comprised of audit results and performance measurement that looks backward to evaluate if appropriate care and services were received, assess compliance with federal and state regulations and contract standards, and examines whether specific interventions have succeeded in meeting established contract requirements, goals, and performance thresholds.

Annual Care Management Audit - Domains include:

- Utilization Review
- Denials and Appeals
- CM Outreach
- CM Engagement
- CM Assessment
- Care Planning
- Care Management Activities
- Pregnancy Care Management
- Lead Care Management
- Disease Management

Sampling Approach: A 10/30 methodology is utilized which is designed from a NCQA model. A sample of 30 files is pulled, and if the first ten show no deficits, the review is complete. If any of the initial ten charts show deficiencies, the remaining 20 are reviewed.

Responsibility:
The Clinical Unit is responsible for completing audits and analysis of data, feedback, and

dialogue with MCOs. Results are presented to the QA&I annually.

MO HealthNet Primary Care Health Homes Program

MCOs are required to ensure collaboration with MHD Section 2703 Health Homes Program for their members. MO HealthNet's Primary Care Health Home (PCHH) Program strives to provide intensive care coordination and care management as well as address social determinants of health for a medically complex population through providing clinical care and wrap around services. One aspect of the program includes the implementation and evaluation of the Patient Centered Medical Home model to:

- Achieve accessible, high quality primary care
- Demonstrate cost-effectiveness to validate and support the sustainability and spread of the model, and
- Support primary care practices by increasing available resources and improving care coordination thus improving the quality of clinician work life and patient outcomes.

The PCHH initiative offers comprehensive care management services for Medicaid participants who have two or more chronic health conditions including chronic pain, asthma/COPD, developmental disabilities, diabetes, cardiovascular disease, overweight/obesity, substance use disorder, depression, anxiety, and tobacco use. The program also emphasizes the integration of primary care and behavioral health care to achieve improved health outcomes.

Behavioral Healthcare Homes Program

Behavioral Healthcare Homes recognized by the Missouri Department of Mental Health under Section 2703 serve to assist individuals in accessing needed health, behavioral health, social services and supports; managing their mental illness and other chronic conditions; improving their general health; coordination with primary care; and developing and maintaining healthy lifestyles.

Individuals covered by MO HealthNet are eligible to be served by a Behavioral Health Home if they have:

- Serious and persistent mental illness;
- Other mental health conditions;
- A substance use disorder, and
- A chronic physical condition listed in the PCHH section above when they are co-occurring in individuals who have serious mental illness, other mental health conditions, and/or substance use disorder.

Disparities Plan (Race, Ethnicity, Primary Language Data Collection)

Missouri updated its procedures for collecting racial and ethnic data consistent with the Office of Management and Budget (OMB) revised standards via Administrative Notice (A-14-2003) on September 11, 2003. Missouri follows the guidance presented in the OMB Administrative Notice for obtaining information when individuals fail to self-identify themselves. The two ethnic categories are: Hispanic or Latino, and Non-Hispanic or Latino. The five racial categories are: American Indian or Alaska Native, Asian, Black, or African American, Native Hawaiian or Other Pacific Islander, Multi-Racial and White. During the application process, the applicant identifies race, ethnicity, and primary spoken language.

The Managed Care contract includes language requirements compliant with Federal regulations. The MCOs are notified of member enrollment/disenrollment information via a nightly enrollment file and a weekly enrollment reconciliation file. To facilitate care delivery appropriate to member needs, the enrollment file also includes race, primary language spoken, and selective health information. The MCOs utilize information on language to provide interpretive services, develop educational materials for employee training, and facilitate member needs in the context of their language requirements.

CMS now requires stratification of HEDIS and Adult and Child Core Set data. This additional detail will allow MHD and MCOs to improve efforts to reduce disparities within our managed care populations and evaluate the need for programs focusing on social determinants of health.

Show-Me ECHO

Show-Me ECHO (Extension for Community Healthcare Outcomes) is part of the University of Missouri's Telehealth Network. Show-Me ECHO uses videoconferencing technology to connect a team of interdisciplinary experts with primary care providers. The discussions with, and mentoring from, specialists help equip primary care providers to give their patients the right care, in the right place, at the right time.

MHD has required all MCOs to participate in this initiative since January 2018. The MCOs collaborate with MHD to develop the focus of the project, create evidence-based goals and expected outcomes, and develop metrics to measure health outcomes and anticipated reduced health care costs. This may include activities such as attending meetings and engaging with existing projects.

The Show Me ECHO projects selected for MCO participation align with MHD concerns and priorities. These include the management of high-risk obstetrics cases, the reduction in the occurrence of neonatal abstinence syndrome, the management of opioid use disorder and the management of chronic pain.

The MCOs collaborate with the University of Missouri and MHD to promote Show-Me ECHO to the health care providers in Missouri, focusing on health care providers in the MCOs' contracted networks.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

EPSDT is a comprehensive preventive and primary health program for Medicaid-eligible children. In Missouri, EPSDT is also known as the Healthy Children and Youth (HCY) Program. EPSDT/HCY is included in the Managed Care contract as a deliverable. Health plans must ensure EPSDT/HCY well child visits are conducted on all eligible members under the age of 21 to identify health and developmental problems. A full EPSDT/HCY well child visit includes the following components:

- A comprehensive health and developmental history including assessment of both physical and behavioral health developments.
- A comprehensive unclothed physical exam
- Health education
- Laboratory tests appropriate to age and health history
- Appropriate immunizations according to age
- Annual verbal lead risk assessment beginning at age six months and continuing through age 72 months using the HCY Lead Risk Assessment Guide Questionnaire
- Blood lead level at 12 and 24 months or annually for all children six to 72 months of age if residing in an area designated as high risk for lead poisoning
- Hearing screening
- Vision screening
- Dental screening (oral exam by PCP as part of comprehensive exam)

MCOs are required to achieve a 65% participant ratio on EPSDT for newborns (infants less than one year old) and children ages one through less than six. Additionally, MCOs must meet the CMS requirement of an 80% participant ratio for members under the age of 21. MCOs submit annual EPSDT data to MHD reporting their participant ratios.

- In addition to the participant ratios, health plans must establish a tracking system that provides information on compliance with EPSDT/HCY services in the following areas: Initial visit for newborns – the initial EPSDT/HCY well child visits shall be the newborn physical exam in the hospital
- Preventative pediatric visits according to the periodicity schedule inclusive of a verbal lead assessment and blood lead tests
- Diagnosis and treatment, or other referrals in accordance with EPSDT/HCY well child visit results

Network Adequacy, Access and Availability of Services and Standards

The Missouri Department of Social Services, MO HealthNet Division is the state agency designated to ensure managed care organizations (MCOs) create and maintain provider

networks with adequate access to care for all covered services, to all managed care participants. MO HealthNet has developed time and travel distance standards that align managed care network adequacy reviews with federal requirements per 42 CFR §438.68, §438.206, §438.358(b)(1)(iv), §457.1218 and §457.1230. The MO HealthNet managed care contract outlines the process for monitoring provider network adequacy. MCOs should use the Provider Network Adequacy Standards document for specific reporting methodology, frequency, and formatting. The Provider Network Adequacy Standards document can be found at https://mydss.mo.gov/mhd/templates-vendor-docs.

MCOs must provide medically necessary services to all members within a timely manner, including those providers not addressed in the Provider Network Adequacy Standards. If a network provider is not available, the health plan must ensure services are covered by an out-of-network provider for as long as the MCOs provider network is unable to provide services. Missouri requires MCOs that enroll AI/AN beneficiaries to demonstrate their networks include sufficient Indian Health Care Providers (IHCPs) to ensure timely access to services for AI/AN populations per 42 CFR 438.14(b) and Managed Care contract section 2.5.19.

MCOs must submit quarterly provider network files to MO HealthNet using the file formats and submission location as directed. Accuracy of the data files is the responsibility of the MCO.

Provider Network Adequacy results are displayed on MHD's website at https://mydss.mo.gov/mhd/network-access and include the following:

- Provider Network Adequacy Dashboard: Displays side-by-side statewide maps of each MCO network, showing coverage by provider type/specialty after applying network adequacy standards. Color coding will represent standards that are met, unmet, or met via exception. Exception details will be provided in notes where applicable.
- MCO Provider Access and Availability Dashboard: Displays side-by-side statewide maps of each MCO network, by provider type/specialty, showing the average and maximum time/distance to providers by county.

MHD will also monitor network access through network development and management plan reports submitted by each MCO.

The EQRO conducts a Secret Shopper Survey to assess MCO compliance with provider directory accuracy and appointment wait times.

Managed Care Contract Standards

In accordance with 42 CFR 438.66, all state quality strategies must provide documentation of Managed Care contract provisions that incorporate the standards of Part 438, Subpart D. Table 6 provides a section-by-section comparison between Subpart D and the July 1, 2022-June 30, 2023 MO HealthNet Managed Care contract. Table 6 shows

that the Managed Care contract's standards related to access to care, structure, operations, and quality measurement and improvement are all at least as stringent as the standards in Part 438, Subpart D. Below is a discussion about standards of particular importance to CMS, MHD, and its members.

Table 6

Managed Care Contract Provisions that Incorporate the Standards of 42 CFR Part 438, Subpart D - Quality Assessment and Performance Improvement	
Federal Rule Section	**Managed Care Contract Section**
438.206 Availability of Services	2.3 Cultural Competency
	2.5 Health Plan Provider Networks
	2.6 Service Accessibility Standards
	2.9 Second Opinion
	2.13.16 Member Handbook
	2.19.9 Credentialing
438.207 Assurances of Adequate Capacity and Services	2.5 Health Plan Provider Networks
438.208 Coordination and Continuity of Care	2.5 Health Plan Provider Networks
	2.6.9 Direct Access and Standing Referrals
	2.12.13 Transition of Care
	2.12 Member Care Management and Disease Management
	2.19 Quality Assessment and Improvement
438.210 Coverage and Authorization of Services	2.6.5 Prior Authorizations
	2.16.2f Grievance and Appeal System
	2.19 Quality Assessment - Utilization Management
438.214 Provider Selection	2.2.8 Non-Discrimination in Hiring and Provision of Services
	2.19 Quality Assessment and Improvement
	2.19.9c Provider Credentialing
438.224 Confidentiality	2.39 Business Associate Provisions
	4.20 Confidentiality
438.56 Disenrollment requirements and limitations	2.13 Eligibility, Enrollment, and Disenrollment
438.100 Enrollee Rights	2.13 Eligibility, Enrollment, and Disenrollment
438.114 Emergency and Post-Stabilization Services	2.7.14 Payment for Emergency Services and Post-Stabilization Care Services
438.228 Grievance systems	2.16 Member Grievance System
438.230 Sub contractual Relationships and Delegation	2.23.13 Subcontractor Oversight Reports
	4.11 Subcontractors
438.236 Practice Guidelines	2.19.5 Practice Guidelines

438.330** Quality Assessment and Performance Improvement Program	2.19 Quality Assessment and Improvement
438.242 Health Information Systems	2.27 Claims Processing and Management Information Systems.
***Formerly located in Section 438.240.*	

Accreditation

MHD requires MCOs to obtain and maintain health plan accreditation from NCQA per the MCO contract. The accreditation status of the three current MCOs is included in table 7 below.

Table 7

NCQA Health Plan Accreditation Status for Current Missouri MCOs		
MCO Name	**Status**	**Expiration Date**
Home State Health/Show Me Healthy Kids	Accredited	4/28/2026
Healthy Blue	Accredited	6/30/2026
UnitedHealthcare	Accredited	7/8/2025

Source: https://reportcards.ncqa.org/health-plans

Section V: Quality Program Assessment Activities

The following is a discussion of several activities that occur at the MCO and Managed Care Program level that will contribute to the ability of the MCOs to achieve the goals, objectives, and measures outlined in the 2024 QIS. For each measure, it may take several different interventions and activities working together to drive change. Development, implementation, and assessment must occur along the way to ensure planned and novel strategies are effective in creating meaningful change. In addition to the 2024 QIS, which is a blueprint for the Managed Care Program as a whole, each health plan is required to implement a Quality Assessment and Performance Improvement Strategy, compliant with CFR 438.330 Quality assessment and performance improvement (QAPI) program. According to the Managed Care contract, this includes components to monitor, evaluate, and implement the contract standards and processes to improve quality in different areas. These areas include performance improvement, quality management, care management, access and availability, and data collection, analysis, and reporting, mechanism to detect under and over utilization and mechanism to assess quality and appropriateness for beneficiaries with special health needs.

External Quality Review Activities

MHD has arranged for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO contract. Comagine Health currently holds the contract for EQR activities. Comagine Health conducts an annual EQR of the MCOs utilizing the EQR protocols (https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf)in accordance with federal requirements 42 CFR 358 and 42 CFR 438.330, and as designated by MHD's Quality Strategy. EQR reports are available on the Department of Social Services, MO HealthNet Division website: https://mydss.mo.gov/mhd/managed-care-health-plans

MHD's EQRO vendor, Comagine Health, completes EQR activities required by CMS, and MHD plans to utilize Comagine Health for special projects designed to improve quality at the agency and MCO level. MHD may enlist Comagine Health to provide technical assistance on special topics that arise during implementation of the QIS. Comagine Health will be involved with the QA&I as well. Table 8 below lists mandatory and optional activities conducted by Comagine Health.

Table 8

EQR Activity (Activities are as allowed by 42 CFR 438.358)	CMS Requirement Status
1. Technical Report	Mandatory
2. Compliance Report	Mandatory
3. PIP: Performance Improvement Project Validation	Mandatory
4. Performance Measure Validation	Mandatory
5. Network Adequacy Validation	Mandatory
6. Technical Assistance for PIPs	Optional
7. Care Management Review	Optional
8. Secret Shopper Surveys	Optional
9. Prior Authorization Audit Development and Activity	Optional

Description of Activities:

Technical Report
A comprehensive and detailed written report that presents findings, results, and recommendations from the EQRO. The report provides an in-depth analysis of the MCO's quality management system, including:
Strengths and weaknesses in quality improvement processes
Areas for improvement in patient care and outcomes
Gaps in compliance with regulatory requirements and industry standards
Recommendations for quality improvement initiatives and corrective actions.

Compliance Report
A report that assesses the MCO's adherence to regulatory requirements, industry standards, and contractual obligations. This report identifies any deficiencies or non-compliance practices and provides recommendations for corrective actions.

Performance Improvement Project (PIP) Validation
A process that evaluates the effectiveness of the MCOs implemented clinical and non-clinical Performance Improvement Projects. The validation involves a review of the project's goals, objectives, and outcomes to ensure that they align with industry standards and best practices.

Performance Measure Validation
A process that assesses the accuracy and reliability of MCO performance measures. The validation involves a review of the data collection process, data analysis, and reporting to ensure that the measures are reliable, valid, and comparable to industry benchmarks.

Network Adequacy Validation
A process that evaluates the sufficiency and accessibility of MCOs provider network. The validation involves a review of the network's composition, geographic distribution, and availability of services to ensure that industry standards and regulatory requirements are met.

Technical Assistance for PIP Validation
A collaborative process that provides guidance and support to MOCs in developing and implementing Performance Improvement Projects. Technical assistance includes expert advice, training, and resources to help MCOs design and validate effective quality improvement initiatives.

Care Management Review
A comprehensive evaluation of MCO care management processes, including assessment, planning, implementation, and coordination of care. The review assesses the MCOs ability to provide patient-centered, cost-effective, and high-quality care.

Secret Shopper Surveys
A technique used to evaluate MCO provider directory and appointment availability. Trained

secret shoppers pose as case managers to assess the MCO responsiveness, accessibility, and quality of care.

Prior Authorization Audit Development and Activity
A systematic review and evaluation of MCO prior authorization processes, including the development of audit tools and methodologies. The audit activity assesses compliance with regulatory requirements, industry standards, and organizational policies, identifying opportunities for improvement and ensuring that necessary care is delivered to members.

Non-Duplication of EQR Activities

MHD's EQR process ensures non-duplication of activities by leveraging existing quality improvement processes and data sources, minimizing duplication of efforts and reducing burden.

The Performance Measure Validation (PMV) activity is a key example of non-duplication in action. The PMV activity utilizes the Healthcare Effectiveness Data and Information Set (HEDIS) performance measures, which are widely used and recognized industry standards. By leveraging HEDIS measures, MHD avoids duplicating effort and resources spent on developing and validating separate measures.
Furthermore, MHD utilizes Final Audit Reports (FARs) to support PMV activities. FARs provide detailed findings from previous audits, allowing for targeted validation and eliminating the need for duplicate data collection and analysis.

MHD's non-duplication approach ensures:

- Efficiency: Reduces duplication of effort and resources
- Consistency: Utilizes industry-standard measures and data sources
- Accuracy: Validates performance data to ensure reliability and accuracy
- Collaboration: Fosters cooperation between MCOs, EQRO, and MHD

By leveraging existing quality improvement processes and data sources, MHD's EQR promotes a culture of quality, accountability, and continuous improvement, ultimately enhancing member care and outcomes.

Information System Capabilities

MCO technical infrastructure has implications for all the activities lined out within the 2024 QIS as well as the ability to measure whether these activities will be able to meet the strategic goals and objectives. The EQRO conducts an Information Systems Capabilities Assessment every three years. They will conduct a "mini review" the following year if an MCO does not obtain a "Met" rating during the prior year's review or if the MCO underwent system changes since the last review. Additionally, the EQRO evaluates encounter data related to performance measures.

Mechanisms to Assess Quality and Appropriateness of Care for Beneficiaries with Special Health Needs

Individuals with special health care needs including those individuals, who, without services such as private duty nursing, home health, durable medical equipment/supplies, or CM may require hospitalization or institutionalization. The following groups of individuals are at high risk of having special health care needs:

- ✓ Individuals with Autism Spectrum Disorder;
- ✓ Individuals with serious mental illness including, at a minimum: schizophrenia, schizoaffective disorder, bipolar disorder, PTSD, major depression, reactive attachment disorder of childhood, disruptive mood dysregulation disorder, oppositional defiant disorder, separation anxiety disorder of childhood and moderate to severe substance use disorder.

To identify persons with SHCN, the choice counselor at the beneficiary support center administers the Managed Care Health Risk Assessment (HRA) to the member during initial and annual open enrollment periods. The choice counselor includes an HRA form for eligible members in each household in the enrollment packet. The choice counselor also administers the HRA via telephone at the time of a telephone change or transfer request. If the mail-in enrollment information does not include a completed HRA, the choice counselor must try to contact the individual by telephone for the information. There should be a health risk assessment for each eligible person in the household. The completed HRAs are provided nightly to the MCOs as they are collected. The MCO is required by contract to make their best effort to conduct an initial screening of each member's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the member is unsuccessful. MHD allows Managed Care enrollment to be completed by telephone, mail, or online at the following location: https://mymohealthportal.com/.

The HRA provides the MCO with important information about the health risks of new members. This provides opportunities for early identification of members who can be referred to care management or disease management. Members with identified health risks have or need one or more of the following:

- Pregnancy
- Special Health Care Needs
- Chronic conditions (asthma, diabetes, high blood pressure)
- Behavioral health treatment or counseling
- Substance use treatment or counseling.

- Physical, speech, or occupational therapy
- Special equipment to help with moving, walking, talking, hearing, breathing, feeding, personal care, etc.

The MCOs have developed condition-specific detailed assessment forms. Based upon assessment results and in partnership with the member, a more detailed care plan may be developed or the appropriate frequency of follow–up outreach identified. Follow-up care may include, specialist referrals, accessing durable medical equipment, medical supplies, and home health services.
Where appropriate, care managers provide coordination and continuity of services to members. MCOs are required to complete a treatment plan for all members meeting the requirements of persons with special health care needs as defined above. All treatment plans must comply with 42 CFR 438.208 and include requirements for direct access to specialists.

Quality Rating System

In the coming years, MHD will establish a Quality Rating System (QRS) for its MCOs developed and required by CMS (42 CFR 438.334 and 42 CFR 457.1240(d)). CMS has established an initial mandatory measure set which consist of 16 measures, including Adult and Child Core Set and CAHPS measures that reflect member experience and access to quality health care. MCOs will be incentivized to improve their quality related to customer satisfaction and health outcomes because the QRS will be required to be displayed on a public website for members to consider when selecting a health plan. Table 9 below lists the QRS Mandatory Measure Set.

Table 9

Measure Name	Measure Description
1. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	The percentage of members who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment. Ages: 1 to 17
2. Initiation and Engagement of Substance Use Disorder Treatment (IET)	The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: • Initiation of SUD treatment. The percentage of new SUD episodes that result in treatment initiation through an

Measure Name	Measure Description
	inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth, or medication treatment within 14 days. • Engagement of SUD treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation. Ages 13 and older
3. Preventive Care and Screening: Screening for Depression and Follow-Up Plan (CDF)	The percentage of members screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up pan is documented on the date of the qualifying encounter. Ages 12 and older
4. Follow-Up After Hospitalization for Mental Illness (FUH)	The percentage of discharges for members who were hospitalized for treatment for selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates for reported: • The percentage of discharges for which the member received follow-up within 30 days after discharge • The percentage of discharges for which the member received follow-up within 7 days after discharge. Ages: 6 and older
5. Well-Child Visits in the First 30 Months of Life (W30)	The percentage of members who had the following number of well-child visits with a primary care practitioner (PCP) during the last 15 months. The following rates are reported: • Well-Child Visits in the First 15 Months.

Measure Name	Measure Description
	Children who turned age 15 months during the measurement year: six or more well-child visits • Well-Child Visits for age 15 months to 30 months. Children who turned age 30 months during the measurement year: two or more well-child visits. Ages: 0 to 15 months and 15 to 30 months
6. Child and Adolescent Well-Care Visits (WCV)	The percentage of members who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year Ages: 3 to 21
7. Breast Cancer Screening (BCS-E)	The percentage of members who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer. Ages: 50 to 74
8. Cervical Cancer Screening (CCS, CCS-E)	The percentage of members who were recommended for routine cervical cancer screening who were screened for cervical cancer using any of the following criteria: • Members 21 to 64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years. • Members 30 to 64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Members 30 to 64 years of age who were recommended for routine cervical cancer

Measure Name	Measure Description
	screening and had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years. Ages: 21 to 64
9. Colorectal Cancer Screening (COL-E)	The percentage of members who had appropriate screening for colorectal cancer. Ages 45 to 75
10. Oral Evaluation, Dental Services (OEV)	The percentage of members who received a comprehensive or periodic oral evaluation within the reporting year. Ages: 0 to 20
11. Contraceptive Care- Postpartum Women (CCP)	Among women who had a live birth, the percentage that: 1. Were provided a most effective or moderately effective method of contraception within 3 days of delivery and 90 days of delivery. 2. Were provided a long-acting reversible method of contraception (LARC) within 3 days of delivery and 90 days of delivery. Ages: 15 to 44
12. Prenatal and Postpartum Care (PPC)	Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these members, the measure assesses the following facets of prenatal and postpartum care: 1. Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the organization. 2. Postpartum Care Rate. The percentage of

Measure Name	Measure Description
	deliveries that had a postpartum visit or between 7 and 84 days after delivery. Ages: all ages
13. Glycemic Status Assessment for Patients with Diabetes (GSD)	The percentage of members with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c (HcA1c) was at the following levels during the measure year: • Glycemic Status <8.0% • Glycemic Status >9.0% Ages: 18 to 75
14. Asthma Medication Ratio (AMR)	The percentage of members who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. Ages 5 to 64
15. Controlling High Blood Pressure (CBP)	The percentage of members who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year. Ages 18 to 85
16. CAHPS	How people rated their health plan: The percentage of members who rated their health plan a 9 or 10, where 0 is the worst health plan possible and 10 is the best health plan possible. Getting care quickly: Composite of the following items: • The percentage of members who indicated that they always got care for illness, injury, or condition as soon as they needed, the last six months. • The percentage of members who indicated

Measure Name	Measure Description
	they always got check-up or routine care as soon as they needed, in the last six months. Getting needed care: Composite of the following items: • The percentage of members who indicated that it was always easy to get necessary care, tests, or treatment, in the last six months. • The percentage of members who indicated that they always got an appointment with a specialist as soon as needed, in the last six months. How well doctors communicate: Composite of the following items: • The percentage of members who indicated that their doctor always noted things in a way that was easy to understand. • The percentage of members who indicated that their doctor always listened carefully to enrollee. • The percentage of members who indicated that their doctor always showed respect for what enrollee had to say. • The percentage of members who indicated that their doctor always spent enough time with enrollee. Health plan customer service: Composite of the following items: • The percentage of members who indicated that customer service always gave

Measure Name	Measure Description
	necessary information or help, in the last six months. • The percentage of members who indicated that customer service always was courteous and respectful, in the last six months. Ages 0 to 17 and 18 and older

MHD is procuring a contract compliance tool, which will automate many of the manual processes for analyzing quality data reports submitted by the MCOs on a monthly, quarterly, and annual basis. The tool will be used to monitor MCO compliance with reporting requirements in the Managed Care contract. The use of this tool will allow MHD to focus efforts on quickly identifying areas of improvement and implementing plans of action instead of the manual process that exists today. A compliance tool will automate our manual process of calculating results of the Performance Withhold program. MHD will use the tool to automate quality rating scores for our MCOs based on criteria established by CMS. Implementation of the compliance tool is planned for 2027, preparing Missouri to comply with production of score cards by December 2028.

Public posting of quality measures and performance outcomes

To improve transparency and accountability of the MO HealthNet Managed Care program, MHD has developed public facing dashboards to display quality measures and performance data received by the plans through reporting requirements. The dashboards are located at the following link and are continually evolving to provide additional information: https://mydss.mo.gov/mhd/quality-dashboard.

Monitoring and Compliance

In accordance with 42 CFR 438.66, all state quality strategies must provide documentation of procedures that regularly monitor and evaluate managed care plan compliance with standards of Part 438, Subpart D.

The State's monitoring program consists of a variety of tools, activities, and reports. Visit https://mydss.mo.gov/media/pdf/mhd-reporting-requirements for a complete list of current MCO reporting requirements.

The Managed Care contract also requires the MCOs to have internal quality assurance programs that MHD regularly monitors. The MCOs, in turn, are responsible for

communicating established standards to their network providers and subcontracted benefit management organizations. They monitor provider compliance, and enforce corrective actions as needed.

Within MHD, the Evidence-Based Decision Support Unit (EBDSU) evaluates process measures, clinical outcomes, and service utilization rates. Measures consist of nationally defined standards as well as locally developed metrics. In addition, the EBDSU houses the Behavioral Health Program, which conducts reviews of behavioral health services within Managed Care, covering a variety of indicators addressing network adequacy, utilization, timely service availability, and hospitalization follow-up, among others. The resulting data from these efforts drive program and policy decisions.

The EBDSU works closely with the Managed Care Policy, Contracts, and Compliance Unit (MCPCCU) and the Quality Oversight Unit. These units act as liaisons with the MCOs regarding required reporting and take necessary steps to ensure compliance. The Performance Withhold Program is housed within the Quality Oversight Unit, which works closely with EBDSU to compile data that are used to evaluate MCO performance.

Adopting and Disseminating Clinical Practice Guidelines

Managed Care quality programs are based on evidence based preventive and clinical practice guidelines. Providers are expected to follow these guidelines and adherence to the guidelines is evaluated by the managed care plans.

As required in Section 2.19.5 of the Managed Care contract each health plan adopts guidelines published by nationally recognized organizations for Medical, Preventive and Behavioral Health care to ensure providers are following best practices for members. Details of the specific guidelines including related conditions, recognized sources and review/adoption dates are detailed in the health plan Quality Assurance Performance Improvement Plan (QAPI).

Guidelines are distributed to all providers and members upon request. Distribution of the guidelines are also provided through newsletters, member and provider handbooks, website and special mailings.

Missouri Medicaid Information System

The Missouri Medicaid Information System (MMIS) supports the initial and ongoing operation and review of the Missouri QIS. In March 2018, CMS notified MO HealthNet that Missouri meets the criteria for a Transformed Medicaid Statistical Information System (TMSIS) because it has met CMS production readiness criteria. CMS recognized Missouri for its commitment to improve data and data analytic capability. The TMSIS solution is sourced from the Business Intelligence Solution Enterprise Data Warehouse

(BIS-EDW). IBM-Watson Health was awarded the contract and implemented the BIS-EDW with MHD in March 2022. MHD is procuring a new MMIS, which will provide the opportunity for even more improvement in this area.

Encounter data are used by the State for rate setting and quality improvement evaluation, and the State conducts a complex process for assuring validity of encounter claims submitted by the MCOs. This involves using software algorithms as well as conducting a review of medical records for a random sample of claims to assure completeness and accuracy of submitted data. Complete and accurate encounter data are important to ensure quality measures such as HEDIS and EPSDT are calculated, reported, and assessed correctly and fairly.

The Managed Care contract includes a requirement that the MCOs must maintain encounter data completeness and accuracy each month. Each MCO must meet a 98% encounter data acceptance rate. In 2020, MHD strengthened contract language to prohibit encounter claims from being held without MHD's prior approval to maintain a 98% encounter data acceptance rate. This is often necessary when system issues occur, or unique programs are implemented, and efforts are required to ensure accurate data is received.

MHD operates an Encounter Data Workgroup (EDWG) consisting of MHD and MCO experts as well as our actuary, Mercer. The EDWG was formed due to inconsistences that prohibited Mercer from using 100% of encounter data when developing rates. Through the success of this group, 100% of encounter data is now used in rate setting processes. The EDWG meets regularly with internal stakeholders and quarterly with Mercer personnel. Topics typically include system edits that result in encounters denying. The EDWG will discuss system requirements, education, and work towards system upgrades when necessary.

MHD also provides an encounter data liaison to the MCOs which can be contacted to work one-on-one to find resolutions to any ongoing problems they may have.

MHD enlisted the assistance of Mercer to conduct triennial encounter data audits of health plan encounter data in accordance with 42 CFR 438.602(e) of the Managed Care Final Rule. MHD received audit results in June 2024 and are continuously working on identified areas of improvement. A summary of results is located at the following link: https://mydss.mo.gov/mhd/managed-care-health-plans

Enrollment Broker

Missouri currently uses a Beneficiary Support Services Center to provide the following enrollment broker functionality:

- Creates and sends enrollment packets and letters to members

- Assigns members into Managed Care health plans
- Forwards data from Health Risk Assessments received by members to MMIS (to compile) who then forwards info to health plans
- Forwards verified Third Party Liability (TPL) data for coordination of benefits.
- Performs choice counselor functionality assisting members with questions by phone regarding plan choices and enrollment into a Managed Care health plan
- Process changing health plans, opt-out, opt-in, and just-cause transfers initiated by members
- MHD recently awarded a contract to Automated Health Systems (AHS) to implement a new Beneficiary Support and Premium Collection Solution and Services Center, which will have the following additional functionality, through a phased in approach, beginning in 2022:
    - Web Portal to assist members in enrolling with a health plan, transfers, opt-in/out, and mailings to be printed or imported by members.
    - Provider directory in the web portal for members to locate PCPs or pharmacies located near them.
    - Auto assignment into health plans with an algorithm approved by MHD.
    - Premium collections module to assist with premium payments for CHIP, Spenddown, and Ticket to Work

The DSS Family Support Division is responsible for determining MO HealthNet eligibility and continues to support MHD and AHS with implementation of the new Beneficiary Support and Premium Collections Solution and Services Center.

Fraud, Waste, Abuse, and Program Integrity

MHD and the Missouri Medicaid Audit and Compliance (MMAC), conducts individual quarterly meetings with each MCO to discuss fraud, waste and abuse trends and activities, and provides program integrity training. The MCOs implement internal controls, policies, and procedures designed to prevent, detect, review, report, and assist in the prosecution of fraud, waste, and abuse activities by providers, subcontractors, and members. Policies and procedures articulate the MCO's commitment to comply with all applicable Federal and State standards.

In 2020, MHD implemented an Overpayments Due to Fraud process in which the MCOs report payments that are in the process of being recouped from providers due to fraudulent activity. MHD shares this data with MMAC to assist them in their audit and compliance activities. MHD also shares this data with our actuary, Mercer Government Human Services Consulting (Mercer), for utilization in rate setting processes.

Sanctions

In accordance with the 42 CFR 438.204, all state quality strategies must provide documentation

of Managed Care contract provisions that incorporate the standards of Part 438, Subpart I related to the appropriate use of intermediate sanctions. Table 10 shows that the current Managed Care contract meets the requirements of Part 438, Subpart I.

Table 10

MO HealthNet Managed Care Contract Provisions that Incorporate the Standards of 42 CFR Part 438, Subpart I - Sanctions	
Federal Rule Section	**Managed Care Contract Section**
438.700 Basis for Imposition of Sanctions	2.30.10 Basis for Imposing Intermediate Sanctions
438.702 Types of Intermediate Sanctions	2.30.11 Types of Intermediate Sanctions
438.706 Special rules for temporary management	2.30.12 Special Rules for Temporary Management
438.708 Termination of an MCO entity contract	2.30.15 Termination of a Health Plan Contract
438.710 Notice of Sanction and pre-termination hearing	2.30.15 c. Termination of a Health Plan Contract
438.730 Sanctions by CMS	2.30.14 Federal Sanctions

The Managed Care contract addresses sanctions in Section 2.30. For each working day that a report or deliverable is late, incorrect, or deficient, the MCO shall be liable to the state agency for liquidated damages as specified in the contract.

In the event the state agency determines the MCO failed substantially to provide one or more medically necessary covered services as required in the Managed Care contract, the state agency shall direct the MCO to provide such service. If the MCO continues to refuse to provide the covered service(s), the state agency shall authorize the members to obtain the covered service from another source and shall notify the MCO in writing that the MCO shall be charged (at the state agency's discretion) either the actual amount of the cost of such service or $500 per occurrence. In such event, the charges to the MCO shall be obtained by the state agency in the form of deductions of that amount from the next monthly capitation payment made to the MCO. With such deductions, the state agency shall provide a list of the members with respect to whom payments were deducted, the nature of the service(s) that the MCO failed to provide, and payments the state agency made or will make to provide the medically necessary covered services. Use of the remedy under this section shall not foreclose the state agency from imposing any other applicable remedy listed herein. The failure to provide a covered service timely (i.e., in accordance with the timeframes specified herein, or when not specified herein, with

reasonable promptness) shall be considered a violation resulting in either the actual amount of the cost of the service or $500 per occurrence.

In the event of any failure by the MCO to provide any services under the contract (including both covered services and administrative services), the state agency may, in addition to any other applicable remedies, require the MCO to submit and follow a corrective action plan to ensure that the MCO corrects the error or resumes providing the service.

Basis for Imposing Intermediate Sanctions

In addition to the above, the state agency may impose intermediate sanctions when a MCO acts or fails to act as specified below. Before imposing intermediate sanctions, the state agency shall give the MCO timely written notice that identifies the violation and explains the basis and nature of the sanction. A MCO is subject to intermediate sanctions if it:

- Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under the contract, to a member covered under the contract.
- Imposes on members premiums or charges that are more than the premiums or charges permitted under the Managed Care program.
- Acts to discriminate among members based on their health status or need for health care services.
- Misrepresents or falsifies information that it furnishes to CMS or to the state agency.
- Misrepresents or falsifies information that it furnishes to a member, potential member, or a health care provider.
- Fails to comply with the requirements for Physician Incentive Plans.
- Distributes directly or indirectly through any agent or independent subcontractor, marketing materials that have not been approved by the state agency or that contain false or materially misleading information.
- Violates any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

Section VI: Summary

MHD intends to use the 2024 QIS to help drive quality improvement on many different levels. MHD is optimistic that the measures included in the 2024 Quality Improvement Strategy will guide the MCOs as they plan and implement activities such as PIPs, care management, provider incentives, and member incentives.

The effort to align quality improvement activities with the goals, objectives, and measures featured in the 2024 QIS will be most effective if it is a collaborative process

between MHD, MCOs and stakeholders. The goal of MHD and its partners is to improve members' appropriate access to care, wellness and prevention, cost-effective utilization of services, and satisfaction with experience of care.

MHD is committed to continuous quality improvement designed to help achieve the Department's mission, to empower Missourians to live safe, healthy, and productive lives.

Appendix A: Quality Strategy Acronym List

AAP - Adult's access to preventive/ambulatory health services
AHS – Automated Health Systems
AMM - Antidepressant Medication Management
BIS-EDW - Business Intelligence Solution Enterprise Data Warehouse
CAHPs - Consumer Assessment of Healthcare Providers and Systems
CBOs – community-based organizations
CBP - Controlling High Blood Pressure
CCBHO – Certified Community Behavioral Health Organization
CCS - Cervical Cancer Screening
CHIP - Children's Health Insurance Program
DHSS - Department of Health and Senior Services
DSS – Department of Social Services
EBDSU - Evidence-Based Decision Support Unit
ECHO - Extension for Community Healthcare Outcomes
EDWG – Encounter Data Work Group
EPSDT - Early and Periodic Screening, Diagnostic, and Treatment
FARs - Final Audit Reports
FFCY - Former Foster Care Youth
FMC - Follow-up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions
FPL - Federal Poverty Level
FUH - Follow-up After Hospitalization for Mental Illness 30 Calendar Days
HCY - Healthy Children and Youth
HEDIS - Healthcare Effectiveness Data and Information Set
HRA - Health Risk Assessment
ICF/DD - intermediate care facility for the developmentally disabled
IHCPs – Indian Health Care Provider
IMD - Institution of Mental Disease
ISCA - Information Systems Capabilities Assessment
LSC - Lead Screening in Children.
MCH - Maternal and Child Health
MCO – Managed Care Organization
MCPCCU - Managed Care Policy, Contracts, and Compliance Unit
MHD –MO HealthNet Division
MMAC – Missouri Medicaid Audit and Compliance
MMIS – Missouri Medicaid Information System
MRT - Medical Review Team
NCQA – National Center for Quality Assurance
OMB - Office of Management and Budget

PCHH - Primary Care Health Home
PCP – Primary Care Physician
PIP – Performance Improvement Project
PMV - Performance Measure Validation
PRS - Prenatal Immunization Status
QA&I - Quality Assessment & Improvement
QAPI - Quality Assurance and Performance Improvement
QDR - Quality Data Review
QIS – Quality Improvement Strategy
QRS - Quality Rating System
RSDI - Retirement, Survivor's, and Disability Insurance
SGA - substantial gainful activity
SHCN – Special Health Care Needs
SSA - Social Security Administration
SSDI - Social Security Disability Insurance
SSI - Supplemental Security Income
TMSIS - Transformed Medicaid Statistical Information System
ToRCH – Transformation of Rural Community Health
TPL – Third Party Liability